STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 92560-001**

v

Priority Health
Respondent
_____/

Issued and entered
this 28th day of October 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On August 12, 2008, Attorney XXXXX, on behalf of his client XXXXX ("Petitioner"), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On August 19, 2008, after an assessment of the material submitted, the Commissioner accepted the request for external review.

Initially this case appeared to involve only contractual issues so the Commissioner did not assign it to an independent review organization ("IRO") for review by a medical professional. Upon further evaluation, the Commissioner determined the case required a medical review. The case was assigned to an IRO which submitted its analysis and recommendation on October 3, 2008.

II
FACTUAL BACKGROUND

The Petitioner has a history of low back pain. He has failed to find relief with medication therapy, physical therapy, and surgery. He believes his best option now is spinal reconstruction

surgery. He requested that Priority Health provide coverage for this surgery to be performed by Dr. XXXXX at the XXXXX Medical Center. Priority Health denied coverage. The Petitioner completed Priority Health's internal grievance process and received its final adverse determination letter dated July 15, 2008.

III
ISSUE

Did Priority Health properly deny the Petitioner coverage for visits and surgery from non-participating providers?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says he has seen many doctors and undergone many tests in an attempt to determine the source of his pain. He has also tried physical therapy, orthotics, and medications (muscle relaxers, Vicodin, ibuprofen, Ultracet, intra-articular injections) to control his pain but none of them have been successful. He had lumbar fusion surgery in 2002 but it was not effective. The Petitioner says the pain is affecting his overall physical functioning, his ability to perform activities of daily living, and work.

He sought treatment at the XXXXX in April and May 2008 on the advice of his brother in-law. In XXXXX he had x-rays and a discogram performed on the affected areas. He says after his tests were reviewed he was given two options: to continue to live with the pain at his current level or to undergo an additional surgery. Continuing to live with his current pain is not acceptable to Petitioner. He believes that the proposed surgery is his best option. He requested coverage for the procedures but Priority Health denied the request.

The Petitioner argues that the operation that he needs is a "tricky one" that should be performed by the best; and there is no one in the Priority Health network who is as capable of performing the surgery as Dr. XXXXX. He says the surgery could affect his ability to walk so he wants a surgeon who has experience. He notes that network physicians have already tried and

he has had a number of problems with their services. The Petitioner says that these problems were visible on his 2007 MRI but no one in-network identified them or addressed them. He says the network second opinion physician is not on a par with the physicians in XXXXX and he therefore wants his surgery performed in XXXXX.

The Petitioner believes that Priority Health should provide coverage for the procedure with the non-participating provider because it is medically necessary, will provide him the best outcome, relieve his pain, and allow him to live a more normal and productive life.

Priority Health's Argument

In its final adverse determination, Priority Health stated that suitable care was available within its provider network from Dr. XXXXX who has completed a research fellowship in orthopedic spine surgery at the XXXXX and a clinical fellowship at the XXXXX Center. In addition; Priority Health indicates it has 456 other participating orthopedic surgeons. Priority Health believes denial of coverage was appropriate since treatment is available from participating providers under the terms of its certificate of coverage.

Commissioner's Review

Priority Health will cover surgery by a non-participating provider if care is not available from a participating provider and if the surgery is pre-approved. The certificate, Section 2 "Obtaining Covered Services," states in pertinent part:

> **C. Referrals**
>
> * * *
>
> Services with a Non-Participating Provider are covered when the standard of care treatment (medically appropriate treatment) for your condition is not available from a Participating Provider. All referrals to or services received from Non-Participating Providers (providers not listed in our provider directory) must be prior approved by us. Referral by your PCP is not sufficient for Coverage of services received from Non-Participating Providers. If you do not receive written approval from Priority Health prior to obtaining services from a Non-Participating Provider, you will be responsible for payment.

Section 7 “Exclusions From Coverage,” includes the following provision:

> The following is a list of exclusions from your Coverage.
>
> * * *
>
> (29) Non-Participating Providers. Non-Participating Providers are those not listed in our provider directory. For the most compete directory, call our Customer Services Department or visit our member center on our web site at *priorityhealth.com*. Services and supplies received from Non-Participating Providers are not Covered, except in the case of a Medical Emergency or if approved by us in writing prior to obtaining the services and supplies. See Sections 2.C and 2.G for requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services.

The Petitioner’s certificate covers surgical services for the treatment of lumbar degenerative disc disease so long as those services are approved in advance. The question therefore becomes is it medically necessary for the Petitioner to obtain care for his condition from a non-participating provider. This question was analyzed in the IRO report which was prepared by a physician who is board-certified in orthopedic surgery and is a Fellow of the American Academy of Orthopedic Surgery and who is a clinical instructor at a university-based school of medicine. The physician is familiar with the medical management of patients with Petitioner’s condition and had access to all the medical records submitted by the Petitioner and Respondent. The IRO physician recommended that Priority Health’s denial of coverage for the University of Minnesota surgery be upheld.

The IRO reviewer’s report includes the following comments:

> This case concerns a fifty one (51) year old male who had a previous spine fusion in 2002 from L4 to S1 to treat a Grade II spondylolisthesis. It was apparently a difficult procedure. Over time, however, his activities decreased and he developed more low back pain. He occasionally has pain and paresthesias in the lower extremities, but the back pain is the primary source of his complaints. On exam, he is overweight, moves easily, and has an essentially normal exam except for straight leg rising causing lower back pain. Imaging studies show a solid fusion L4 to S1. He had positive discography at L4/5 with concordant pain and non-concordant pain at L3/4. Flexion/extension films show physiologic motion at L3/4 and no motion at L4/5.

> Recommendations have been made for treatment for this enrollee that range from anterior lumbar discectomy and fusion at L4/5 to removal of hardware, osteotomies of L4/5 and L5/S1, with anterior and posterior fusions of L3 to the Sacrum.
>
> All of the surgeons are giving poor prognostications regarding surgical treatment. One surgeon opines "I have advised him that despite all of his tests and all of our technology, the results of treating axial back pain of this sort are quite dismal." A second surgeon indicates that "given the pseudomeningocele [a complication of the previous surgery] the probability of dural tear is very high."
>
> This reviewer would recommend a non-operative approach to this enrollee's condition. The potential complication rate from either surgery is remarkably high (particularly in light of the difficulty that was encountered at the previous surgery), and in this reviewer's opinion significantly outweighs any potential improvement this enrollee might gain as a result of surgery (which is quite low by all indications).
>
> Since the reviewer was asked to choose between two unattractive options, this reviewer would choose the single level anterior body fusion of L4/5 as being the less unattractive treatment. This procedure requires less surgical time, exposure, and risk. This surgery is more likely to address the primary pain generator at L4/5. The proposed osteotomies of the lumbar spine are more designed to address cosmetic issues and not functional or pain issues; therefore, this reviewer would mot recommend that procedure.
>
> There is no reason or this enrollee to seek "out of network" providers. Any spine surgeon doing regular spine fusions should be able to adequately perform either of these procedures, although it is this reviewer's opinion that few surgeons would recommend either procedure.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded deference by the Commissioner; in a decision to uphold or reverse an adverse determination the Commissioner must cite "the principal reason or reasons why the commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b) The IRO's analysis is based on extensive experience, expertise, and professional judgment. The Commissioner can discern no reason why that judgment should be rejected in the present case. Therefore, the Commissioner accepts the findings of the IRO that Petitioner's evaluation and proposed surgery in Minnesota is not

medically necessary in light of the resources available within the Priority Health network. Priority Health's denial of coverage was consistent with the terms and conditions of the certificate and state law.

V
ORDER

Respondent Priority Health's July 15, 2008, final adverse determination is upheld. Priority Health is not required to provide coverage for the out-of-network treatment sought by Petitioner.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

Ken Ross
Commissioner